



The Risk and Prevention of Maltreatment of Children with Disabilities

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"Maltreatment of individuals with disabilities may be committed by only a few, but the responsibility to protect them belongs to us all."

—Mitchell & Buchele-Ash, 2000, p. 239

Child maltreatment, also known as abuse and neglect, affects all types of children, but children with disabilities may be at even greater risk of being maltreated than children without disabilities. Why? And what can be done to prevent maltreatment of children with disabilities? This document considers the scope and nature of the problem and ways to prevent it in light of current research. (This document will not address issues of reporting, assessing, investigating, or treating maltreatment of children with disabilities.)

What is the scope of the problem?

Researchers have had difficulty estimating rates of maltreatment among children with disabilities. One reason is that States do not collect the same data about maltreated children in the same ways. Another reason is that researchers identify disabilities among maltreated children in different ways.

Maltreatment is generally defined using the Federal Child Abuse Prevention and Treatment Act (CAPTA) definition¹, but States vary in their guidelines used to substantiate, or identify, maltreatment. Disability is generally defined using the Federal Americans with Disabilities Act (ADA)², but only 19 States record pre-existing disabilities on their Child Protective Services (CPS) forms (Bonner, Crow & Hensley,

1997), so researchers must use other means to identify disabilities among children who have been maltreated. Given these difficulties, "The real extent of the problem . . . remains a frightening unknown" (Mitchell & Buchele-Ash, 2000, p. 227).

Nonetheless, available research has found that children with disabilities are more vulnerable to maltreatment than children without disabilities. The only national study conducted to date (Crosse, Kaye & Ratnofsky, n.d.), was completed in 1993. The study found that children with disabilities were 1.7 times more likely to be maltreated than children without disabilities. Crosse et al. used data from NIS-2, the second congressionally mandated National Incidence Study of child maltreatment. (NIS-1 was completed in 1980, NIS-2 in 1988, and NIS-3 in 1996.) The Crosse et al. study indicated that while 21.3 per 1,000 children *without* disabilities are maltreated each year, 35.5 per 1,000 children *with* disabilities are maltreated each year. Put another way, approximately 175,000 to 300,000 U.S. children with disabilities are maltreated each year, if it is estimated that between 9 percent and 15 percent of all children in the United States have a disability of some kind.

Crosse et al. acknowledge that their study may underestimate the incidence of maltreatment of children with disabilities. A study conducted in Omaha, Nebraska, in 1997 found that children with disabilities were 3.4 times more likely to be maltreated than were children without disabilities (Sullivan & Knutson, in press). Although the

Omaha study did not use a national sample, its findings underscore the need for more research on the scope of the problem.

These are the only two recent studies that have attempted to measure the scope of the problem. (Twenty-two studies were conducted in the United States between 1967 and 1992 [Sobsey, 1994], but this document addresses only the most current research.) To assist in understanding their findings, it is helpful to understand a little about their methodology. Table 1 presents some of

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Table 1: Methodological Components of Crosse et al. and Sullivan & Knutson Studies		
Methodological Components	Crosse et al., not dated	Sullivan & Knutson, in press
Sample population of maltreated children without disabilities	1,600	3,491
Sample population of maltreated children with disabilities	234	1,012
Target sample	Nationally representative sample of 35 CPS agencies	Total enrollment in Omaha, NE, public schools, including early intervention programs
Data gathering time period	Early 1991	1994-95 school year
Data gathering method	Prospective--reviewed incoming cases for 4-6 weeks with follow-up calls to workers	Retrospective--merged databases from public schools, social services and law enforcement
Eligibility criteria for maltreatment	Substantiated CPS investigations	Substantiated CPS and law enforcement investigations
Eligibility criteria for disability	CPS workers' assessments of the presence of disabilities	School system records indicating children approved for special education using NE Department of Education regulations
Perpetrator groups	Primarily familial perpetrators (many CPS agencies did not investigate non-familial cases)	Familial and non-familial

this information.

What are the characteristics of victims and perpetrators?

Some researchers have compared the characteristics of maltreated children with and without disabilities. Studies also have looked at characteristics of the adults who maltreat children with disabilities.

Studies that compared the characteristics of maltreated children with and without disabilities reported different findings:

- Crosse et al. (n.d.) found that maltreated children with disabilities were generally older than maltreated children without disabilities
- Sullivan and Knutson (in press) found they were generally the same age
- Wolcott (1997) found they were generally younger.

In addition, Crosse et al. found that maltreated children with disabilities were disproportionately white as compared to maltreated children without disabilities, but Wolcott found the proportions of both groups who were white to be about the same. All

three studies found that maltreated children with disabilities were more likely to be male than maltreated children without disabilities, although it should be noted that more males are diagnosed with disabilities.

Most studies of adult perpetrators indicate that the majority of perpetrators are family members; this is true for maltreated children with and without disabilities (Crosse et al., n.d.; Sullivan & Cork, 1996). Among all family members, mothers are most frequently the perpetrators of maltreatment (Crosse et al., n.d.; Sullivan & Knutson, in press), although it should be noted that mothers are most often the primary caretakers of children (Sobsey, 1994). However, sexual abuse of children with disabilities is more often committed by males who are not relatives of the victims; this is also true for children without disabilities who are sexually abused (Sobsey, 1994; Sullivan & Knutson, in press).

Non-family members who maltreat children with disabilities come in contact with their victims in many different ways. Perpetrators can include teachers, health care providers, residential care providers, transportation staff, volunteers, babysitters, and peers (Ammerman & Baladerian, 1993; Sobsey, 1994).

Is there a relationship between the type of maltreatment and type of disability?

Some studies have explored the relationship between the type of maltreatment and type of disability. Child welfare agencies generally group maltreatment into four categories: physical abuse, sexual abuse, neglect, and emotional maltreatment. Table 2 shows findings from two studies that explored the likelihood that children with disabilities will experience a particular type of maltreatment.

These studies both found that neglect was the most common form of maltreatment for children with disabilities as well as for children without disabilities. Sullivan and Knutson (in press) also found that "children with disabilities tended to be maltreated multiple times and in multiple ways" (p. 9).

Both of these studies (Crosse et al. and Sullivan & Knutson) also explored which types of disabilities place children at greatest risk of maltreatment. Disabilities examined in both studies include mental retardation, speech/language impairments, emotional disabilities, learning disabilities, and physical health impairments. Sullivan and Knutson also

Table 2: Likelihood of Maltreatment of Children with Disabilities Compared to Children without Disabilities, by Type of Maltreatment		
Type of Maltreatment	Crosse et al., not dated	Sullivan & Knutson, in press
Neglect	1.6 times as likely	3.8 times as likely
Sexual Abuse	1.8 times as likely	3.1 times as likely
Physical Abuse	2.1 times as likely	3.8 times as likely
Emotional Maltreatment	2.8 times as likely	3.9 times as likely

included hearing and visual impairments. Both studies found that of all types of disabilities, emotional and behavioral disorders showed the highest prevalence rate of abuse and neglect. Sullivan and Knutson (in press) found that children with behavioral disorders were at highest risk, followed by children with speech/language disorders, mental retardation, and health impairments. Crosse et al. (n.d.) found that serious emotional disturbance puts children at the highest risk, followed by learning disabilities, speech/language impairments, and physical health problems. (To fully understand these findings, it is helpful to understand each study's methodology. See *References* for a complete list of citations.)

Why are children with disabilities at higher risk for maltreatment than children without disabilities?

Researchers have identified a number of factors related to parents, children, families, service systems, and society at large that increase the potential for maltreatment of children with disabilities (Ammerman, 1997; Burrell, Thompson & Sexton, 1994; Mitchell & Buchele-Ash, 2000; Sobsey, 1994; Steinberg & Hylton, 1998). However, there is disagreement among researchers regarding the legitimacy of certain risk factors. The intention of this section is to describe the major findings in this area.

There is general acceptance that no single factor places any child at risk for abuse and neglect. Rather, it is the interaction of factors that seems to be important. Sobsey (1994) proposes the integrated ecological model of abuse to explain the interaction of factors that may lead to abuse or neglect. Sobsey's model (which is based on

Bronfenbrenner's ecological model of child development) takes into account cultural and environmental factors as well as characteristics of the parent and child and their interactions. When using this model for abuse prevention, Sobsey focuses particularly on power inequities between the potential offender and potential victim.

Some of the factors that place children with disabilities at risk for abuse and neglect are the same factors that place all children at risk (Ammerman & Patz, 1996; Sobsey, 1994; Tomison, 1996). But many factors are more connected to disability-related issues (Tomison, 1996).

General Risk Factors for All Children

Certain factors related to parents are associated with increased risk of maltreatment for all children. Parental substance abuse is a risk factor identified by many researchers (Sobsey, 1994; Steinberg & Hylton, 1998; Wolcott, 1997). Other parent-related risk factors are poor coping skills, poor impulse control, and a history of violence (Ammerman & Baladerian, 1993; Sobsey, 1994). Parents with low self-esteem or who have been diagnosed with depression may be at greater risk for maltreating their children (Sobsey, 1994; Sullivan & Cork, 1996) as may be parents who were victims of child maltreatment themselves (Jones, Peterson, Goldberg, Goldberg, & Smith, 1995; Sobsey, 1994). Parents who are disabled may be at risk for maltreating their children, especially if they were raised in group care and lacked positive parenting models (Sobsey, 1994).

Factors Related to Disability

These include factors related to society, stress, families, the children, and non-familial caregivers.

Societal risk factors. Many researchers believe that societal attitudes and beliefs play a significant role in placing children with disabilities at risk for maltreatment. Steinberg and Hylton (1998) contend that some institutionalized beliefs, practices, and policies "devalue" children with disabilities. This may be manifested in ways that indicate children with disabilities are not as worthy of social, educational, or professional opportunities as children without disabilities. Children with disabilities may internalize societal attitudes and feel shame or feel less worthy of being treated respectfully (National Resource Center on Child Sexual Abuse, 1994). Sobsey (1994) adds that segregating children with disabilities tends to increase the perception of differences and suggests that "... group membership and social distance influence our attitudes about the acceptability of violence. Attitudes about individuals or groups that tend to depersonalize, dehumanize, or distance them appear to make violence against them more acceptable" (p. 307).

In addition, myths associated with children with disabilities can increase risk. Sobsey (1994) discusses the myth held by many that children with disabilities are not vulnerable to abuse; belief in this myth can result in a lack of awareness and attention to the problem. Steinberg and Hylton (1998), citing Baladerian (1994), discuss myths such as:

- Children with disabilities are asexual and therefore do not need sex education (denying them

information that may help to prevent abuse)

- Some children with disabilities are unable to manage their own behavior (resulting in caretakers exerting unnecessary control)
- Some children with disabilities do not feel pain (resulting in aversive therapies being used)
- All caretakers are special and good (resulting in a lack of awareness and attention to signs of abuse or neglect).

Stress as a risk factor. Many researchers propose that stress is a critical factor in child maltreatment (Ammerman, 1997; Burrell, Thompson & Sexton, 1994; Rycus & Hughes, 1998; Tomison, 1996), while others say that little research supports this theory (Benedict, Wulff & White, 1992; Sobsey, 1994). And while stress may be a risk factor for some families, Sobsey states that most families that have children with disabilities do not, in fact, respond abusively to stress.

Those supporting stress as a risk factor point to the increased demands of caring for children with disabilities, which may involve daily assistance with bathing, dressing, eating, transporting, and providing medical care (Ammerman & Baladerian, 1993; Rogow & Hass, 1999; Tomison, 1996). They also discuss the difficulties of coping with challenging behaviors such as temper tantrums, aggressiveness, and noncompliance (Ammerman, 1997; Jones, et al., 1995; Tomison, 1996). Some children with disabilities require much supervision and highly structured and consistent limit-setting (Ammerman & Patz, 1996; Kragthorpe, et al., 1997). In some cases, parents' lack of knowledge about caring for their children with disabilities can be a factor in their ability to cope with their children's needs. This lack of knowledge can result in unrealistic expectations for the children (Ammerman, 1993; Kragthorpe, et al., 1997).

A lack of resources can exacerbate a parent's stress. Most often discussed is a lack of social support, resulting in isolation of the family from their community. Sobsey (1994), citing Smith (1984), states that "A large body

of research indicates that isolation from society increases risk and inclusion in society decreases it" (p. 160-1). Researchers have also explored the relationship between stress and a lack of financial resources and available services and their contribution to risk of maltreatment (Steinberg & Hylton, 1998). Poverty and/or inadequate supportive services can create stressful situations within a family. Ammerman and Patz (1996) and Rycus and Hughes (1998) specifically mention a lack of access to respite care as a risk factor. Without support for the family, parents may feel isolated, have little personal time for themselves, and become overwhelmed by their responsibilities (Ammerman, 1993; Tomison, 1996).

Familial risk factors. Many of the risk factors identified by researchers are specifically related to the family's reaction to the child with the disability. For example, the risk of maltreatment may be higher if the parents view the child as "different" and unlike any other child, if they "mourn" the loss of a "normal" child and become angry (Rycus & Hughes, 1998), or if they see the disability as an embarrassment or perceived punishment (Burrell, Thompson & Sexton, 1994).

Another potential risk factor involves unhealthy attachment or disruptions in the bonding and attachment between parent and child. Sobsey (1994) explains that healthy attachment is characterized by mutual pleasure and pain; if one individual suffers, the other suffers, and vice versa. Unhealthy attachment disrupts this mutuality. "Sadly, information given to parents by professionals at the time disability is diagnosed often implicitly or explicitly contains the message—'Don't get too attached to this child.'" (Sobsey, 1994, p.161-2). Disruptions in attachment can occur if there are frequent hospitalizations or if the child is unresponsive or unaffectionate (Ammerman & Patz, 1996; Sobsey, 1994; Tomison, 1996).

Some researchers have found that risk for maltreatment is higher for children with mild disabilities, and speculate that this could be because parents have expectations for them that cannot be fulfilled (Ammerman & Patz, 1996;

Benedict, Wulff & White, 1992). Some researchers found a higher risk of neglect when parents could not, or did not, provide the level of care required by the child's disability (Ammerman & Baladerian, 1993; Jones, et al., 1995; Rycus & Hughes, 1998).

Child-related risk factors. Numerous risk factors related to the child with the disability have been identified. In actuality, many of the factors discussed here are considered "socially mediated effects of disability." This refers to people's *response* to the child with a disability, rather than to the child or the disability itself. Although some feel that viewing child-related characteristics as risk factors is "victim blaming" (Tomison, 1996), it is important to note these characteristics, especially in conjunction with the many other factors already discussed.

Because the care required by some children with disabilities is critical to their survival, many have been taught to obey those in authority and comply with their caretakers' requests or demands (National Resource Center on Child Sexual Abuse, 1994; Steinberg & Hylton, 1998). In fact, some children with disabilities may feel that their bodies don't belong to them (National Resource Center on Child Sexual Abuse, 1994; Steinberg & Hylton, 1998; Tobin, 1992). If a caretaker behaves inappropriately, a child may not complain or resist because he or she believes the caretaker knows what is best.

Many researchers have found that some children with disabilities lack the knowledge or understanding to know when behavior is wrong or inappropriate (Ammerman, 1992; Steinberg & Hylton, 1998; Wolcott, 1997). Even if they do recognize behaviors as wrong, some children with disabilities may not attempt to stop the abuse or neglect because they fear losing the relationship; they are emotionally dependent on their caretakers (National Resource Center on Child Sexual Abuse, 1994; Tobin, 1992). In some cases, their disability may prevent them from being able to defend themselves or escape (Ammerman, 1992; Steinberg & Hylton, 1998). Finally, children who

have difficulty communicating may be at a higher risk for maltreatment because potential perpetrators may believe they can “get away with it,” thinking that the child will not be able to report the behavior (Ammerman & Patz, 1993; Wolcott, 1997). “[C]hildren with disabilities may be perceived as being relatively ‘safe victims.’” (Dr. Frieda Meacham in National Symposium on Abuse and Neglect of Children with Disabilities, 1994).

Risk factors for institutional and non-familial abuse and neglect.

Although maltreatment is most often perpetrated by family members, children with disabilities often are cared for by others, and the risk for maltreatment is present in these circumstances. Characteristics of institutional abuse include extreme power and control inequities, dehumanizing and detachment from the children, clustering of vulnerable children with those who might harm them, isolation of children, and an abusive subculture (Sobsey, 1994; Steinberg & Hylton, 1998). As with parents, issues of attachment can be factors in the risk for maltreatment by non-family caregivers. Sobsey (1994) states “Often paid caregivers are deliberately discouraged from becoming attached to clients by the ethic of professional detachment and the organizational needs of agencies.... The relatively weak bonds that formulate between staff and the people they serve cannot be expected to deter abuse...” (p. 162).

What can be done to prevent abuse and neglect of children with disabilities?

As Ammerman and Baladerian (1993) state, “The physical, emotional, and financial costs of abuse and neglect are so great as to make prevention the number one priority in the effort to eliminate maltreatment of children” (p. 9). If abuse or neglect does occur, it is important to report, investigate, and treat the problem. But it is equally important to address efforts to prevent abuse and neglect. Prevention may be

aimed at the general public (known as primary prevention) or targeted specifically to families considered at risk of child maltreatment (known as secondary prevention). (A third form of prevention, not covered in this document, is known as tertiary prevention and is designed to prevent maltreatment from reoccurring.)

Because different, interrelated factors can contribute to child maltreatment, different, coordinated prevention strategies are needed. A multifaceted approach may be the most effective. Approaches may be parallel, in which separate programs are implemented for children with disabilities, or integrated, in which the needs of children with disabilities are accommodated in generic programs serving all children.

Prevention at the Societal Level

One of the first steps in prevention is raising awareness of the problem. Heightened awareness can lead to more funding for research and prevention programs and better programming to combat the problem. The National Symposium on Abuse and Neglect of Children with Disabilities (1995) recommended that 10 percent of Federal funds for child abuse awareness be devoted to disability issues.

Most experts in the field also recommend coordination among relevant parties to ensure that prevention efforts are comprehensive. Governments, services providers and local communities can work together to support families that have children with disabilities, and professionals from many fields can collaborate (Rogow & Hass, 1999). Educators and health care professionals, who are often in contact with children with disabilities, can be trained to understand the problem and their role in preventing it (Wolcott, 1997). One study found that 92 percent of special educators would attend specialized training if it were made available (Orellove, Hollahan & Myles, 2000).

At the societal level, prevention efforts often focus on changing societal attitudes about children with disabilities. The National Symposium

on Abuse and Neglect of Children with Disabilities (1995) and Sobsey (1994) recommend promoting inclusion of children with disabilities into everyday life. Steinberg & Hylton (1998) add recommendations including the encouragement to value children with disabilities, see them as individuals and share responsibility for their well-being. Sobsey (1994) adds recommendations such as educating others specifically about people with disabilities, challenging negative attitudes and behaviors and personalizing interactions.

Mitchell and Buchele-Ash (2000) advocate enacting legislation that supports prevention and protection of children with disabilities. For example, the Federal Crime Victims with Disabilities Awareness Act of 1998 was enacted to increase awareness of crimes committed against people with disabilities (including child abuse and neglect), collect data, and develop strategies to address the needs of this population. Mitchell and Buchele-Ash also advocate for adoption of more prevention measures and provision of self-protection education for children with disabilities.

Family-focused Prevention Efforts

Because much of the maltreatment of children with disabilities occurs within families, many prevention efforts focus on services to families. Goals of family-focused prevention efforts include increasing knowledge and understanding about the child’s development; strengthening parenting skills; improving awareness of, and access to, resources; reducing isolation; and developing positive coping skills (Kragthorpe, et al., 1997; Rycus & Hughes, 1998; Steinberg & Hylton, 1998). Services can either be offered to all families that have children with disabilities or to families considered to be at risk of maltreating their children.

One service offered to all families that have children with disabilities is the Individualized Family Service Plan (IFSP). The IFSP is required by the Individuals with Disabilities Education Act (IDEA) for families and their young children with disabilities from birth to

age 5. The IFSP includes a multidisciplinary assessment, goal setting and planning, linkage to services, and coordination and monitoring of services (Jones, et al., 1995). Parent involvement is critical to ensure that the plan addresses all of the family's identified needs.

The case management component of the IFSP is an important one. Case managers can advocate for and help coordinate a myriad of resources needed by families (National Symposium on Abuse and Neglect of Children with Disabilities, 1995; Rycus & Hughes, 1998). These services can include educational, medical, and recreational programs for the children; financial assistance for the families; respite care; counseling; and parenting programs. Parenting programs may provide information about the child's disability and realistic expectations for the child's development and may teach positive parenting skills (Ammerman, 1997; Rycus & Hughes, 1998; Sobsey, 1994).

One type of family-focused prevention program that is available to at-risk families that have children with disabilities involves home-visits by trained professionals or para-professionals (Jones, et al., 1995). (Home visitation programs are also widely available for many types of at-risk families.) Home visitation programs often start before or soon after the birth of a child to help build family strengths from the beginning, and may continue until the child is 5 years old. "Home-based services . . . set the stage for services and support that are flexible, culturally competent, and responsive to family-identified needs...." (Sandall, 1997).

Another type of family-focused programming is called Parent-to-Parent support. Parents of children with disabilities can trade information on resources and problem-solve together when agency people are not available (i.e., after working hours). Parents who are at risk of maltreating their children with disabilities can benefit by talking with other parents in similar situations (Jones, et al., 1995). They may express vulnerabilities and explore painful options with other parents in ways they

wouldn't feel comfortable doing with a professional. A survey conducted in 1996 found that "Parent to Parent support increases parents' sense of being able to cope [and] ... increases parents' acceptance of their situation" (Santelli, Turnbull, Marquis & Lerner, 1997, p. 78). In 1997, there were more than 500 local and 25 statewide Parent to Parent programs serving more than 35,000 parents nationally (Santelli, et al., 1997).

When targeting prevention programs to at-risk families, Sobsey (1994) states that it is important to identify the risk factors in families so programs can set priorities and tailor services to individual families. Many professionals discuss the need to focus on reducing the effects of stress on families that have children with disabilities (Burrell, Thompson & Sexton, 1994; Crosse et al., n.d.; Struck, 1999). For example, Rycus & Hughes (1998) state that services must address three factors in the stress equation:

- Reduce situational and psychological stress
- Strengthen the family's ability to cope and to access supportive resources
- Help the family achieve a realistic perception of their situation.

Family-focused prevention services are an important component in the overall effort to prevent abuse and neglect of children with disabilities. Tomison (1996) says that services should be available as long as a family needs them; once services are pulled out, the family that had been able to cope may fall apart. Public funding and medical insurance coverage are key factors in the availability, accessibility, and longevity of services delivered to families of children with disabilities.

Child-focused Prevention Efforts

Child maltreatment prevention programs are rarely made available or accessible to children with disabilities (Baladerian, 1994), often due to a lack of funding or a mistaken belief that this population does not need prevention information. In actuality, "[w]ithholding knowledge from

individuals with disabilities concerning self-protection increases their vulnerability to abuse and neglect" (Mitchell & Buchele-Ash, 2000, p. 235).

Ammerman and Baladerian (1993) say that child-focused prevention programs for children with disabilities should include sharing information about abuse (how to identify it, how to respond to it, how to tell others) and talking about feelings that may occur if abuse is attempted. In addition, Briggs (1995) states that parental involvement throughout the program is crucial to ensure all family members are aware of and support the program's teachings. A number of researchers talk about the need for more appropriate and accessible programming for children with disabilities (Baladerian, 1994; Kragthorpe, et al., 1997). Kragthorpe states that programs need to be inclusive and sensitive to ability levels, culture, and gender. Steinberg & Hylton (1998) recommend using developmentally appropriate concepts, concrete activities, and audiovisual aids. They also recommend, as does Baladerian in the National Symposium on Abuse and Neglect of Children with Disabilities (1995), that prevention programs for children with disabilities be ongoing rather than a one-shot effort; children with some disabilities may need lessons repeated frequently.

Many programs provide specific information about abuse—what it is, how to recognize it, and what rights children have (Ammerman & Baladerian, 1993; Sobsey, 1994; Tobin, 1992). In addition to education, teaching assertiveness skills is often mentioned as a component of prevention efforts (Baladerian, 1994; Sobsey, 1994; Tobin, 1992). However, Baladerian (1994) cautions that simply telling children with disabilities to say "no" to an adult is often not useful because they are taught to strongly respect and comply with adults in authority. Finally, many abuse prevention programs teach safety and self-defense skills (Baladerian, 1994; Sobsey, 1994; Wolcott, 1997). However, Sobsey (1994) states "... it is important to recognize that many abused people with disabilities, as with other victims of abuse, face extreme

power inequities that no amount of individual training can overcome” (p. 178).

Prevention of Non-familial Abuse and Neglect

Much of the literature examining prevention of non-familial abuse and neglect of children with disabilities focuses on the policies and procedures of agencies providing services to this population. These include careful screening of job applicants, training for staff in positive behavior management techniques, effective staff/client ratios, realistic staff expectations, strong supervision and support, and an explicit commitment to child protection (The Beach Center on Families and Disability, 1997; Kragthorpe et al., 1997; Sobsey, 1994; Steinberg & Hylton, 1998). The National Symposium on Abuse and Neglect of Children with Disabilities (1995) and Steinberg and Hylton (1998) also add that programs should have unannounced checks and investigations conducted by outside agencies. In addition, The Beach Center on Families and Disability (1997) adds that “An open environment that welcomes families has proven to be very effective in reducing abuse and neglect” (p. 2).

Families can play a role in preventing abuse and neglect by other caregivers. Ammerman and Baladerian (1993) say that a parent getting to know and being involved with a child’s caretakers can be a deterrent to maltreatment. They add that parents should tell people who care for and interact with the child that the child has been trained in abuse prevention techniques and should discuss abuse awareness with their child.

Conclusion

Children with disabilities are more at risk of abuse and neglect than children without disabilities. The factors that place these children at higher risk include factors that place all children at risk of maltreatment in addition to other risk factors that are more directly related to disabilities. These include:

- Societal attitudes about disabilities
- Peoples’ reactions to, and interactions with, children with

disabilities (including family members and non-family caregivers)

- Factors that relate to the disability itself
- Program policies and procedures governing the care of children by others.

Primary prevention efforts can improve conditions for all families that have children with disabilities and secondary prevention programs can target children and families who are at high risk of maltreatment. Prevention strategies can attempt to improve:

- Societal attitudes
- Federal policies
- Family dynamics
- Children’s knowledge and safety skills
- Programs’ policies and procedures.

To justify more funding for prevention programs, including services for children and families and training for professionals, further research is needed to understand the scope and nature of the problem. Better documentation of disabilities in the Child Protective Services system would assist in this process. Current prevention programming should be evaluated to determine its effectiveness. Finally, as Sobsey (1994) states, “... before this problem can be successfully managed, society must adopt attitudes that allow all of its members to see the problem, recognize that it must be addressed, and believe that meaningful change is possible” (p. 304).

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Endnotes

¹ The definition of "child abuse and neglect" from the Child Abuse Prevention and Maltreatment Act (CAPTA):

"The term 'child abuse and neglect' means, at minimum, any recent act or failure to act on the part of a parent or caretaker, which results in death, serious physical or emotional harm, sexual abuse or exploitation, or an act or failure to act which presents an imminent risk of serious harm." 42 U.S.C.A. §5106g(2) (West Supp. 1998)

² The definition of "disability" from the Americans with Disabilities Act (ADA):

The term "disability" means, with respect to an individual –

- (A) a physical or mental impairment that substantially limits one or more of the major life activities of such individual;
- (B) a record of such an impairment; or
- (C) being regarded as having such an impairment. 42 U.S.C. §12102(2) (1999).

The phrase physical or mental impairment includes, but is not limited to, such contagious and noncontagious diseases and conditions as orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional illness, specific learning disabilities, HIV disease (whether symptomatic or asymptomatic), tuberculosis, drug addiction, and alcoholism. ADA Title III Technical Assistance Manual Covering Public Accommodations and Commercial Facilities §36.104(1)(iii).